Nephi Smiles Family Dentistry
(435)580-5055
54 N. Main Street, Nephi UT 84648
www.NephiSmiles.com

Patient Information Form

Patient's Name: _____ Birth Date: _____ Today's Date: _____

Address: _____ Social Security No.: _____

City, State, Zip: _____ Email: _____

Home/Cell Phone: _____ Work Phone: _____ Marital Status: _____

Responsible Party: _____ Home Phone: _____

Responsible Party's Birthday: _____ Responsible Party's Social Security No: _____

How did you hear about us? _____ Responsible Party's Work Place: _____

Pharmacy: _____ Pharmacy Phone: _____

Insurance Company: **Group #:** _____

Subscriber ID:

Sex: ☐

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N		
☐	☐	Do you smoke or use tobacco?	Height:
		For Office Use Only BP _____ Heart Rate: _____	Weight:

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Dental History

Reason for Visit: _____

Date of Last Dental Visit: _____

Please Check all that apply:

	TMJ/pain in jaw joint		Gum Recession		Sensitivity to sweets
	Gums bleed easily		Orthodontic treatment		Periodontal/gum treatment
	Broken teeth or fillings		Sensitivity to hot and/or cold		Sores/lumps in or near mouth
	Pain/aching in teeth		Clench or grind teeth		Dentures or partials
	Frequent headaches		Clicking/jaw popping		

Signature: _____ **Date:** _____

(If under 18, Parent or Guardian Signature Required)